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The World Health Organisation

WHO in crisis

Fiona Godlee

This is the first in a series examining the role of the World Health Organisation, its current problems, and its future prospects

Media attention has been focused on the leadership of the World Health Organisation, rather than on the real factors that limit WHO's effectiveness. These factors relate to the organisation's structure and also to its current priorities, methods, and management. This article examines the objectives and strategy of WHO in view of financial constraints and donor countries' demands; WHO's stated goal of integrated primary health care; staff morale; and the growing dislocation between the regions and headquarters.

The World Health Organisation has an image problem. People know that it exists, and most people know that it eradicated smallpox, but few have a clear idea what it does. Of those I have spoken to, some think it is a sort of world medical association, others see it only as a source of standard technical medical reports, yet others as just another faceless United Nations body where overpaid bureaucrats carve out their careers. Some politicians and doctors in Britain see it as meddling in public health matters that need not concern it when it should be concentrating its efforts on the developing world. Doctors in the developing world respect the WHO for its technical advice and support but criticise the waste of money on salaries and bureaucracy. Its slogan "Health for All by the Year 2000" has entered the international vocabulary, but few people, apart from diehard enthusiasts in the organisation, believe the target can be realised or understand how WHO intends to achieve it.

The media woke up to WHO last year when political and financial scandal seemed set to erupt over the re-election of its director general, Dr Hiroshi Nakajima. The outcome of an external audit fell short of media hopes; it found financial mismanagement and misuse of the organisation's funds but they cleared the director general of any involvement.[1] Amid the reportage of seedy dealings and the repetition of mainly unsubstantiated stories, the real factors that limit WHO's effectiveness received little attention.

It is these factors that I will be exploring in the next few weeks. They relate mainly to the structure of the organisation but also to its current priorities, methods, and management. In order to understand its problems, I have spoken to staff at WHO, former staff, diplomats, civil servants, politicians, and doctors. I have interviewed the director general and attended the annual meeting in Geneva of WHO's governing body, the World Health Assembly. I have also visited two of the regional offices, in Delhi and Copenhagen, and interviewed five of the six regional directors. In this article I will summarise the main criticisms of WHO, first describing its objective and strategy.

Objective and strategy

WHO's objective, as laid down when the organisation was founded in 1948, is "the attainment by all people of the highest possible level of health," where health is defined as complete physical, mental, and social wellbeing and not just the absence of disease and infirmity.[2] WHO's strategy is to act through member states, advising their governments on technical matters, financing the training of local health professionals, and trying to influence health policy decisions.

WHO does not, except with rare exceptions, intervene directly in health care provision or disease prevention—a strategy designed to avoid charges of imperialism and ensure that developments are sustainable in the long term. But this strategy presents the organisation with important problems. Not only is it a major source of misunderstanding (WHO is frequently criticised for its lack of activity "in the field," to which staff reply wearily that "that is not the WHO's role") but it means that WHO has no direct powers to improve people's health. Its success relies entirely on the receptiveness and effectiveness of national governments and the fidelity with which other agencies like Unicef translate its principles into action.

Financial constraints and donors' demands

WHO's activities are seen by many as disparate and uncoordinated. They range over the whole gamut of health issues, from major threats to life such as AIDS and tuberculosis to lesser threats like oral disease. WHO remains committed to what it calls the "full menu" approach and aims to encompass all aspects of health care. Critics say, however, that there is little logic to how resources are allocated and that diseases of the developed world take up a disproportionate amount of WHO's time and money.[3] Donors would like to see WHO focus its attention on a smaller number of essential programmes mainly in the developing world, and they are calling for WHO to set itself clearer priorities in keeping with its limited resources.[4]

WHO is suffering the same financial straits as the rest of the United Nations. Unpaid contributions, largely from the former Soviet Union but also from the

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Views of WHO: misconceptions but with some truth

WHO should be more visible in the field, handing out vaccines and helping with emergency relief

WRONG—WHO's role is to advocate and advise countries on health care and disease prevention, not to implement interventions. Its aim is to influence long term policy decisions. Its constitution specifies that it should work through national governments, to assist them "upon request, in strengthening health services."

BUT—Some of WHO's most visible and effective programmes, including the smallpox eradication programme, have involved direct intervention. The onchocerciasis control programme, which has already achieved its 1995 target of eliminating the disease as a public health problem, provides drug treatment and case finding facilities and has its own helicopters for spraying blackfly breeding grounds. Many critics believe that WHO should stick to this approach.

WHO is a centralised bureaucracy based in Geneva

WRONG—WHO is one of the most decentralised of the United Nations agencies. It divides the world into six regions, each with its own regional office, which have a high degree of autonomy from Geneva.

BUT—The decentralisation is largely illusory since WHO's efforts do not easily penetrate beyond the regional offices. WHO's effectiveness in individual countries is variable but often poor. It depends on the energy of country representatives, who are generally undertrained and underresourced.

WHO wastes vast amounts of money

WRONG—Of the four biggest United Nations agencies (in terms of the number of staff), WHO spends the least. Its biennial budget for 1994-5 is \$1·8bn, compared with annual NHS spending of \$60bn.

BUT—The most recent external audit found that, despite financial constraints, money is wasted on bureaucratic inefficiency and petty corruption.[5]

WHO spends too much on staff

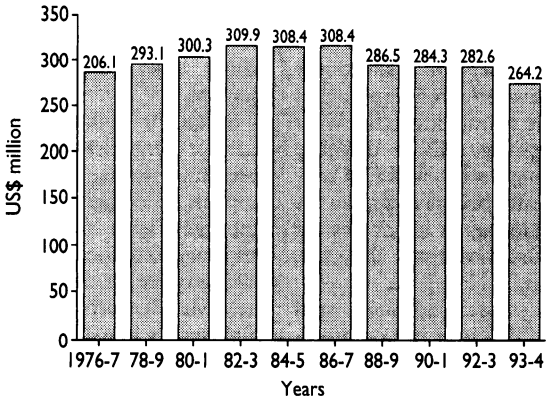
WRONG—WHO is its staff. Its technical advisory and advocacy roles rely entirely on staff activities.

BUT—It does not always attract the best people for the job. The director general believes this is because the United Nations does not pay well enough. Most people think it pays too well and that political appointments and quota systems conspire against achieving meritocracy or excellence. Recent attempts to slim down the payroll have proved largely ineffective.

United States, have left it with a biennial income deficit of \$51m.[5] Meanwhile, donor countries (those countries that give funds in addition to their membership fees) are demanding more value for money and a greater say in how their money is spent. They have achieved both objectives in a way that has left WHO increasingly dispersed and uncoordinated. Instead of putting the additional money into WHO's central pot, they are using so called extrabudgetary contributions to support freestanding programmes within WHO. These programmes have their own management committees, which include representatives from donor countries, and they are out of the World Health Assembly's control. Donors can choose which programmes to support and can withdraw money if they don't like what is being done. The situation pleases recipient countries as much as donors. This is because WHO's budget is made up of countries' membership fees, which are based on their population and income. The budget has been frozen by the World Health Assembly for the past 13 years and is losing ground against inflation (figure). As a result, each country's contribution to the budget is falling in real terms, but the extrabudgetary contributions from donors ensure that money is still available for recipient countries.

It is WHO that loses out. These freestanding or vertical programmes are generally disease specific, dealing, for example, with malaria, AIDS, and diarrhoeal diseases. Their increasing share of the money and the limelight detracts from WHO's routine activities within member countries, especially its efforts to establish integrated networks for primary health care. WHO says that such networks are developing but that their success depends on economic and social development and the existence of an adequate infrastructure, factors over which WHO has little control. Critics maintain, however, that WHO has failed to promote primary health care effectively and that the organisation's efforts in individual countries are hampered by the lack of a clear strategy. A report from the Danish overseas development organisation, Danida, concludes that WHO's budget in individual countries is used for "ad hoc financing of fellowships, study tours, workshops, local cost subsidies and miscellaneous supplies and equipment" rather than being allocated according to a strategic plan.[6]

Some critics also fear that WHO's priorities now reflect donors' preferences rather than rational allocation of resources. In the absence of central priorities, much depends on the energy with which individual programmes lobby for support. Behind the single face of WHO are warring factions arguing over territory and funds, to the confusion of donors and recipients.



WHO's working budget has been frozen for the past 13 years and is losing ground against inflation

Changes in definition of health

WHO's position has been further weakened by its failure to adapt to changes in the definition of health itself. For years male and medical, health has become increasingly multisectorial—encompassing disciplines such as education, development, sociology, and anthropology—and oriented towards women's health and women practitioners. WHO has been slow to respond. Few of its professional staff are women and most of them are medical. Staff are increasingly frustrated by the realisation that the major determinants of health—poverty, education, development, and the environment—are beyond the scope of WHO.

WHO's representatives in recipient countries are stationed inside ministries of health, which limits their influence, especially since health is traditionally one of the government departments with the lowest status. Observers say that the WHO's country representatives are the weak link in an already weak chain of influence, from the organisation's headquarters in Geneva through its six regional offices into national ministries of health. Seen as political appointees, they are given no structured training and few resources and they are often poorly motivated.

Under new management

WHO's structural flaws have become increasingly evident since the change of leadership in 1988. After 15 years under the charismatic visionary Dr Halfden Mahler, WHO staff and donors were unimpressed by Dr Hiroshi Nakajima, who they saw as reserved and a poor communicator. Today people outside the organisation fear that under his direction WHO is losing ground to other international agencies. They see WHO retreating from Dr Mahler's high profile approach, which made the organisation an influential advocate of international equity and rational use of resources, back into its traditional role of setting standards and providing advice on technical medical matters. Dr Nakajima has the support of developing countries, but Western donors worry about WHO's loss of influence under his direction. Last year they took the unprecedented step of asking Japan to withdraw his candidature for re-election. His re-nomination by the executive board led to allegations that Japan had exerted undue pressure on developing countries, including threats to withdraw trade and aid agreements if they did not vote for Dr Nakajima. Opponents also alleged that WHO's funds had been misused to influence the election.

An external audit to examine the allegations found no corruption but criticised WHO for shortcomings in management and found that the number of contracts let to members of the executive board had doubled in the six months leading up to the election. In his report the external auditor, Sir John Bourne, recommended changes in the regulations governing the letting of contracts to board members. A further report, from a working party of the executive board, chaired by Britain's chief medical officer Dr Kenneth Calman, called for wide ranging changes to WHO's internal organisation.[8] This year's routine external audit found that little had been done in response to either report.

Supporters of Dr Nakajima say that the international climate has changed since Dr Mahler's time and that the worldwide recession has forced donors to demand greater accountability. They argue that under such scrutiny the old leadership would also have been found wanting. Some international observers comment that Dr Nakajima's technical emphasis and conciliatory style—brokering compromises between conflicting vested interests—is perhaps the best approach for WHO in the current climate. As one commentator said, "Countries in the developing world have had enough of the strong man style. They don't take kindly anymore to outspoken, objective oriented approaches to health care." Others note the strong tide in the West towards deregulation and growing calls to dispense with international nannies. They feel that WHO may have to stand back for a while until people again see the need for international bodies to act as advocates for equity and social justice. In the meantime, they say, WHO could do a lot worse than Dr Nakajima.

But even Dr Nakajima's most dedicated staff acknowledge that his severe difficulties in communicating are a major handicap for a United Nations leader. His spoken English and French are poor, and even Japanese delegates and staff find him difficult to understand. When he speaks privately his passion for the work of WHO is evident, as well as his grasp of the problems it faces; but under stress—at press conferences, for example—he becomes defensive and incoherent. His attempts to establish what he has called "a new paradigm for health" have floundered in a maze of incomprehension.

In the absence of coherent policy and strategy direction, conflicts within the organisation are rife. Departments fight over territory rather than cooperating, and communication between them is poor. "All communications have to go through heads of divisions and up through the hierarchy," said one programme director. "The result is that the right hand never knows what the left hand is doing." WHO's internal structure reflects these personal infightings, with units being allocated to divisions not on a logical basis but according to who has what.

A dive in staff morale

Staff complain that Dr Nakajima's management style is autocratic. The director general has absolute power to hire and fire within headquarters and can post members of staff to any region. Directorial appointments are made at his discretion, bypassing the senior staff selection committee. Under previous director generals such discretionary posts were rarely appointed. Under Dr Nakajima their number has gone up from 66 in 1988 to 114 in 1994 (see table). The number of top ranking employees (above director level, all earning around $80 000 a year) has nearly doubled since Dr Nakajima took office, from seven in 1988 to 13 today. "We used to have only directors. Now there are executive directors, acting directors, associate directors, and assistant directors," said a senior staff member. "These promotions might be acceptable in a private firm, but they are paid for out of public funds. We feel embarrassed."

Discretionary appointments in WHO

	1988	1994
Deputy director general	1	0
Special representatives*	0	1
Assistant director general	5	6
Executive directors	0	2
Special rate advisers	1	4
Director D2	24	39
Director D1	1	5
Professional P6	34	57
Total senior staff	66	114
% Of all WHO staff	1·7	2·6

*To United Nations Relief and Works Agency for Palestine Refugees in the Near East.

No overall policy informs these decisions at present, according to staff representatives in Geneva. When experienced technical staff retire their posts are frozen to save money, causing some programmes to collapse and making it difficult for others to make long term plans. Meanwhile, at senior administrative level promotions have been made beyond the top grade of salary scale recommended by the UN secretary general.

Since Dr Nakajima took office the International Labour Organisation, to which WHO answers on personnel issues, has received an increasing number of appeals from aggrieved staff. Several of the subsequent tribunals have found disregard of the rules and arbitrary decisions by the director general. Soon after taking office he demoted the then director of personnel, Mr Herbert Crockett, over a dispute about Dr Nakajima's housing allowance. A tribunal found that Mr Crockett's demotion was illegal and ordered WHO to reinstate him. He is now employed elsewhere in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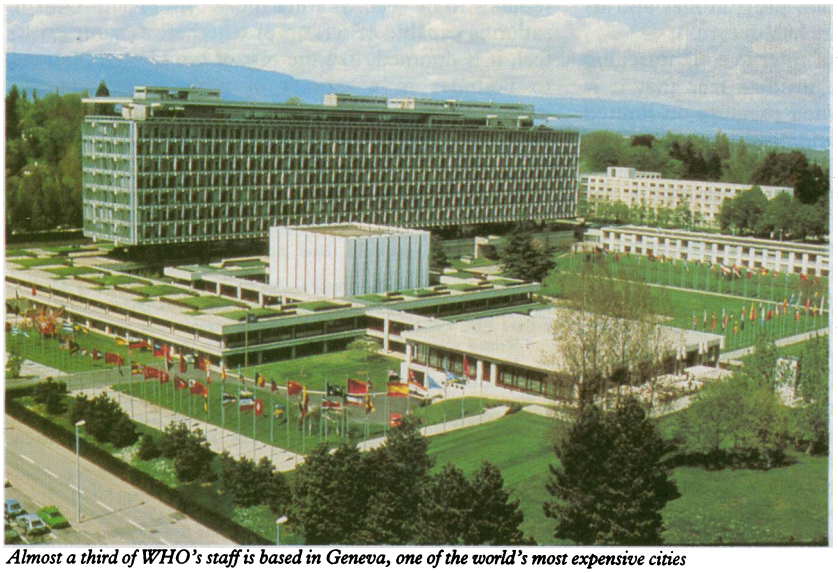
Dr Hiroshi Nakajima, WHO's director general



WHO

Almost a third of WHO's staff is based in Geneva, one of the world's most expensive cities

the Geneva headquarters. In his place Dr Nakajima appointed a retired member of staff, Mr Mustafa Latif, on repeated short term contracts that enabled him to continue to draw his pension for four years while also receiving a salary. The current director of personnel, Mr Dario Sanvincenti, is a former supply officer with almost no previous experience in personnel management.

The staff association's lawyer in Geneva, Mr Klaus Samson, believes that there is now a serious problem with the way WHO handles its staff. "WHO used to have a good reputation as an employer," he said, "but there has been a striking increase in the number of cases going to tribunal in the past few years and a striking increase in the number that have found against the organisation; six in the past half year." The most recent successful appeal was lodged by a German medical technician, Mrs Gabriele Mussnig, who claimed unfair dismissal and sexual harassment by WHO's representative in Angola, Dr Emmannuel Ben-Moussi. The ILO found she had been unfairly dismissed and ordered WHO to reinstate her. The tribunal found that WHO had wrongly denied Mrs Mussnig access to her files and tried to prevent her from exercising her right to appeal. The report also said that WHO made no attempt to deny the accusations of sexual harrassment and, despite being a signatory to the United Nations declaration against sexual harassment, has failed to take action against its representative in Angola. He remains in post having received, according to the tribunal report, only a "putative reprimand."[7] "The case is more than just sexual harassment," said the chairman of WHO's staff committee, Dr Jan Stjernsward. "What the judgment brought out is the arbitrariness of the administration and a denial of due process."

Staff morale in Geneva is low and standards are reported to be slipping. Staff talk about growing inertia and an atmosphere of distrust. Skilled technical staff who are able to find jobs outside the organisation are leaving, while those with less chance of finding the same salary elsewhere and those with mainly administrative skills are staying on. Recruiting good replacements is proving difficult. Despite being insulated to a large extent from the discontent in Geneva, some of the regional offices report similar difficulties in recruitment. Lack of motivation is reflected in an increasing fixation among staff about pay, promotion, perks, and allowances.

Staff are WHO's main commodity. Salaries take up a large proportion of the budget, and almost a third of the organisation's employees are based in Geneva, one of the world's most expensive cities. Staff numbers have increased by nearly a fifth over the past six years, from about 3800 in 1988 to 4500 today, and recent attempts to slim down the payroll have been only partially successful. A voluntary redundancy scheme, intended to save the organisation $4·4m, ended up costing $4·9m in severance payments, and some of the 47 vacated posts have subsequently been refilled.[5] In the face of deepening financial crisis, failure to reduce staff numbers means less and less money for implementing WHO policy.

The regions

Staff in the six regional offices are insulated from the discontent and internal politics in Geneva, but they are embroiled instead in regional politics. For regional directors, getting reelected means maintaining the support of the regional committees, made up of delegates from the ministries of health of member states. Recent reports have questioned the amount of time and energy that regional directors devote to regional politics,[6] and there are growing calls for an overhaul of the way in which regional directors are selected.[4]

Many are also concerned about the growing dislocation between the regions and headquarters. The regional directors have never been directly answerable to the director general or to WHO's governing body, the World Health Assembly, and they enjoy wide-ranging discretionary powers over setting policy, awarding jobs and fellowships, and allocating resources. Their independence was, however, tempered in the past by Dr Mahler's strong personality. Observers say that Dr Nakajima does not command such respect from the regional directors, a fact that has further distanced the regional offices from Geneva's control.

WHO is concerned

WHO is clearly concerned about the criticisms levelled against it. Its apparent openness to scrutiny and readiness to provide information and access to staff are in striking contrast to the generality of international bureaucracies. The staff I spoke to were painfully aware of the organisation's problems and talked openly about them, though few would speak on the record. They seemed deeply committed to WHO's objectives and strategy.

My overall impression is of an organisation whose system conspires against the best efforts of its staff; where staff appear overworked but often have little to show for their efforts; where despite all the institutional barriers a few exceptional people achieve impressive results. As one insider said, "WHO is like an enormous beehive. Some cells work extremely effectively, with dedicated workers doing excellent work against the odds. But there are whole chunks of it that are rotten and where nothing happens."

Conclusion

The World Health Organisation has unique resources in terms of people, knowledge, and experience, but it is suffering a crisis of confidence, both internally and internationally. Sensing the organisation's lack of direction, donors are finding other agencies to invest in. The resulting financial crisis is now preventing the organisation from functioning effectively. In the absence of strong leadership, three long-hidden fault lines in WHO's structure are opening up: the dislocation between management and staff; the dissociation between headquarters and the regional offices; and the contradiction between WHO's

high profile, vertical intervention programmes and its stated goal of integrated primary health care.

WHO is entering a period of intense soul searching and internal upheaval. Some insiders fear that it is tearing itself apart. With growing pressure on limited resources, donors are demanding more value for money and greater accountability. Reports from the United Nations, from donors, and from within the WHO itself are demanding radical reform.[4 6 8] The articles that follow will explore the problems faced by WHO and some possible solutions.

Even WHO's most vociferous critics agree that some form of international health organisation is necessary. The world needs a strong body to take the lead in health matters, to act as an advocate for equity in economic and social development, to set priorities for the use of limited resources, to provide neutral territory for debating sensitive issues, and to give technical advice and support. Such a role can be successfully taken only by an organisation that commands respect and is seen to be above national politics and free from divisive internal wranglings. It remains to be seen whether the World Health Organisation is capable of reform or whether, as some critics feel, it is doomed, like the rest of the United Nations, to flounder in a morass of petty corruption and ineffective bureaucracy. These articles will, I hope, stimulate a much needed debate on WHO's future.

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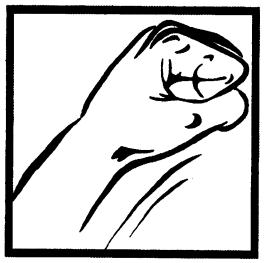
Controversies in Management

Screening for carriers of cystic fibrosis

Screening before pregnancy is needed

J A Raeburn



This is the eleventh in a series of articles examining some of the difficult decisions that arise in medicine

I believe that carrier testing for the common cystic fibrosis mutation (Δ F508) should be offered in the United Kingdom before conception, to adults who wish it, after receiving and reading an informative explanatory leaflet. This is simple, unambiguous, and relatively inexpensive. The proposal recognises an individual's right to make an informed choice and separates that choice from life situations such as pregnancy, in which there is pressure to consider only specific options.

Three issues need to be considered: providing and receiving accurate information; whether a person wishes to know if he or she carries a testable mutation of the cystic fibrosis gene; and making a person understand that if the result shows him or her to be a carrier relatives should be told and offered testing.

The carrier screening programme should not aim to achieve a high uptake of screening. If 10% of the population of reproductive age chose to be tested during the first year it would be acceptable and appropriate. Success depends on a slow initial response as the community learns about cystic fibrosis; uptake could increase as the programme proceeds.

In previous approaches to screening a low uptake has been seen as inadequate and they have sought the higher rates achieved in pregnancy screening.[1-4] Why? An early low response is the bedrock of an ethically directed programme. The views of our communities vary.[5]

Why screen now?

Why should we start screening now, when health care costs and especially new developments are under close scrutiny? The answer lies in the importance of individual informed choice across different groups of the community. Tests for carriers of thalassaemia or sickle cell disease have been performed since the 1970s among ethnic groups in which they occur. Screening for Tay-Sachs disease has also been offered for five years. Indeed, much of our knowledge of genetic screening has come from the careful studies of Asian, Afro-Caribbean, and Jewish groups.[6 7] What is so different about cystic fibrosis that should make us delay testing now?

Opponents of screening for carriers of cystic fibrosis suggest that there is a danger of stigmatisation of people found to be carriers.[8 9] Yet counselling and testing procedures should be confidential. The result would be known to those outside the family only if the person had chosen to tell. Stigma depends on someone being seen to be different and on the community's false assumption that different people are threatening; such labelling shows a lack of knowledge and a need for social education. A slowly developing screening programme would allow people to understand more gradually and should decrease any stigma.

Eugenic policies of 60 years ago are also cited as a reason for withholding cystic fibrosis screening. If this is true, why is it appropriate to offer screening for the commonest recessives in Asians, Afro-Caribbeans, Jews, and southern Europeans? If all people in our community are encouraged to make an informed choice about screening the responses will be diverse. The differing choices exercised will result in the opposite of a directive eugenic policy.

How should we screen?

If instead of focusing on high uptake we aimed at providing a high degree of individual choice, screening before pregnancy would enable more people to choose their preferred package with the same number of tests.

For example, if couple screening were offered to

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